AUDIT/ DATE OF REVIEW/VISIT_____ CONDUCTED BY_____

REHABILITATIVE MENTAL HEALTH
FOR
CHILDREN UNDER THE AUTHORITY OF DHS

Division of Child and Family Services

AUDIT TOOL FY2016
In Home, Non-Medicaid

AGENCY_____ CLIENT_____

TELEPHONE #_____ CLIENT MEDICAID #_____

MAILING ADDRESS_____ _____

SITE ADDRESS_____

FAX#_____ E-MAIL _____

CONTACT PERSON_____

DATE OF ADMISSION _____ SERVICE CODES_____

DATE OF DISCHARGE_____

CASE MANAGER/REGION_____

PSYCHOLOGICAL EVALUATION

NAME OF CLIENT: _____

COMPLETED BY:_____ TITLE: PhD_____MD_____
(IF STUDENT, CERTIFIED OR INTERN) SUPERVISED
BY:_____TITLE:_____

DATE COMPLETED:_____

TOTAL POSSIBLE POINTS: 12

Service codes:	NXH	$132.44 ($120.95)	Psychological Testing
	NXN	$132.44 ($120.95)	Neuropsychological Testing Battery
	NXD	$132.44 ($120.95)	Developmental Testing
	NXB	$132.44 ($120.95)	Neurobehavioral Status Exam

	COMPLIANCE	**COMMENTS**
1. Performed by a licensed physician, psychologist or a certified psychology resident working under the supervision of a licensed psychologist		
2. Report includes the date(s) and actual time(s) and duration of testing/interpretation.		
3. Report includes setting in which the testing was rendered.		
4. Written test reports include: a. Brief history b. Tests administered c. Test Scores d. Evaluation of test results e. Current functioning of the examinee f. Diagnosis g. Prognosis h. Specific treatment recommendations for mental health services	_____ _____ _____ _____ _____ _____ _____ _____	
5. Report includes signature and licensure of individual who rendered the service		

DIAGNOSTIC INTERVIEW EXAMINATION

COMPLETED BY:_____ TITLE: CMHC____LCSW____PhD____MD____
APRN.(Advanced Practice Psychiatric
Mental Health Nurse Specialist)_____
Licensed Family & Marriage Therapist_____
(IF CERTIFIED OR INTERN) SUPERVISED BY:_____ TITLE:_____

DATE COMPLETED:_____

TOTAL POSSIBLE POINTS PER FILE: 9
Service codes: NCA $33.16/15 min. ($30.29) PDE, Mental Health Therapist
NPE $33.16/15 min. ($33.16) PDE, MD/APRN
NCN 33.16/15 min. ($12.29) Psychosocial Portion by Non-Mental Therapist

	COMPLIANCE	COMMENTS
1. Completed by a qualified mental health provider.		
2. Face to Face evaluation and includes date of service		
3. Includes date and actual face-to-face time of service, including start and end time (rounded to nearest five minutes).		
4. Duration of the service including time for interpretation, dispersion, and reporting.		
5. Includes the setting in which the service was rendered.		
6. Includes history and evaluation of client's emotional, mental, social, basic living skills, educational, mental and physical status. (Mental Status Exam)		
7. Includes a disposition including diagnosis (DSM-IV/ICD-9).		
8. Includes summary of recommended mental health treatment services.		
9. Includes Signature and licensure of individual who rendered the service.		

TREATMENT PLAN

COMPLETED BY:_____ TITLE:_____

DATE COMPLETED:_____

TOTAL POSSIBLE POINTS PER FILE: 11

Service Codes: NCA $33.16/15 min. ($30.29) PDE, Mental Health Therapist
NPE $33.16/15 min. ($33.16) PDE, MD/APRN

	COMPLIANCE	COMMENTS
1. Completed by a qualified mental health provider who either did the examination or who will be providing treatment.		
2. Completed at same time or after the Diagnostic Interview Examination and within 30 days of referral.		
3. Completed prior to treatment and designed to improve and/or stabilize the client's condition.		
4. Coordinated with the Division's Service Plan and Treatment Team.		
5. Includes measurable goals that relate to client's mental health needs.		
6. Goals are individualized and reflect needs identified in the Examination.		
7. Includes tx regimen or specific tx method(s) to be used on each goal.		
8. Includes the frequency/duration for each method per goal.		
9. Includes the credentials of the staff responsible for providing the service.		
10. Discharge criteria per contract		
11. Copy provided to Case Manager within 15 days of completion		

TREATMENT PLAN REVIEW

COMPLETED BY:_____ TITLE:_____

DATE COMPLETED:_____

TOTAL POSSIBLE POINTS PER FILE: 8

***The Contractor shall bill for a treatment plan review as family psychotherapy or individual psychotherapy (if there is a face-to-face interview with the Client), depending on how the treatment plan review is conducted.**

Service codes:	NCA	$33.16/15 min. ($30.29)	PDE, Mental Health Therapist
	NPE	$33.16/15 min. ($33.16)	PDE, MD/APRN
	NFC	$30.20/15 min. ($27.19)	Individual Therapy
	NFT	$27.19/15 min. ($27.19/15)	Family Therapy w/Client Present

	COMPLIANCE	**COMMENTS**
1. Completed by a qualified mental health provider who has sufficient face-to-face contact with the client to determine progress toward treatment goals.		
2. The Plan is reviewed at least quarterly or when there is a change in the client's condition.		
3. The review includes the date, actual time (rounded to the nearest 5 minutes) and duration of the service. (Recommend: record time of completion of document, and time of review with client) (Recommend: client signs review)		
4. The review includes a written update of progress toward goals, appropriateness of the services being furnished, and need for continued services.		
5. The Contractor shall review the tx plan quarterly face-to-face interview with the Client to review progress toward each tx objective. The Contactor may also participate in a CFTM as part of the review process.		
6. Discharge criteria updated including post discharge plans and coordination of related community services to ensure continuity of care with the client's family. **(Recommendation Only)**		
7. Includes Signature and licensure of the individual who rendered the service.		
8. A copy was sent to Case Manager within 15 days of the end of each review period.		

PROGRESS NOTES

	COMPLIANCE	COMMENTS
Individual/Family Psychotherapy (per session) **Service Codes:** NFC $30.20/15 min. ($27.19) Individual Therapy NFT $27.19/15 min. ($27.19) Family Therapy w/Client NFW $27.19/15 min. ($27.19) Family Therapy w/o Client 1. Provided by a qualified mental health provider a. Date and actual face to face time with the client. This includes the start and end time rounded to the nearest five minute interval. b. Duration of the service. c. Setting where the service was rendered. d. Individuals present in the session (for family therapy). e. Specific service rendered. f. Treatment goal(s). g. Clinical note describing the client's progress toward tx. goal(s). h. Signature and licensure of individual who rendered the services. TOTAL POSSIBLE POINTS PER FILE: 8/9		
Group Psychotherapy (per session) **Service Code:** NGT $6.33/15 min. ($6.33) Multi-Family NGT $6.33/15 min. ($6.33) Non-Multi-Family 1. Provided by a qualified mental health provider a. Date and actual face to face time with the client. This includes the start and end time rounded to the nearest five minute interval. b. Duration of the service. c. Setting where the service was rendered. d. Number of clients in group psychotherapy session. e. Specific service rendered. f. Treatment goal(s). g. Monthly or per session clinical note describing the client's progress toward treatment goal(s). h. Signature and licensure of individual who rendered the services. If a clinical note summarizing progress toward tx goals is written for each group session, then a monthly progress note **is not** also required. TOTAL POSSIBLE POINTS PER FILE: 9		

PHARMACOLOGIC MANAGEMENT (Per session) **Billing code:** NMM $81.01 ($81.01) Pharmacologic Mgmt, Prescriber NMR $40.72 ($35.41) Parmacologic Mgmt, RN 1. Provided by a qualified mental health provider 2. Service was face to face 3. Medication order or copy of the prescription signed by the prescribing practitioner 4. Documentation includes the date and actual time of the service 5. Documentation includes the duration of the service 6. Documentation includes the setting where the service was rendered 7. Documentation includes the treatment goal(s) 8. Documentation summarizes: a) condition for which meds are needed b) medications prescribed c) dosage d) results of review e) summary of the information provided f) if meds administered, name of medication and method of administration g) if applicable, summary of assessment and monitoring of other health issues h) progress toward goal or if no progress, the reasons/barriers 9. Documentation includes legible signature and credentials of person who rendered the service. TOTAL POSSIBLE POINTS PER FILE: 17		

Must be billed for each date of service on separate claim lines.

Intensive Supervision - Mentoring (Non-Medicaid) **Billing Code:** YIS $3.31/15 min. Intense Supervision Mentor/Tracker 1. Must be 21 years of age or older 2. Must have HS diploma or GED 3. Must have 3 written references from non-related persons 4. Valid driver's license, verified annually 5. Maintain auto insurance consistent with contract requirement 6. Training is the same as a direct care staff 7. Documentation: a) Dates of services and activities b) Start and end times of services and activities c) Description of service/activity d) Name of individual who provided the service/activity 8. Copy of activity log given to Case Manager within 3 working days after the end of each month. TOTAL POSSIBLE POINTS PER FILE: 12		

<u>Day Group Skills Support Services (Non-Medicaid)</u> **Billing Code:** DGS 1.26/15 min. Day Group Support 1. Must be 21 years of age or older 2. Must have HS diploma or GED 3. Must have 3 written references from non-related persons 4. Valid driver's license, verified annually 5. Maintain auto insurance consistent with contract requirement 6. Training is the same as a direct care staff 7. Documentation: e) Dates of services and activities f) Start and end times of services and activities g) Description of service/activity h) Name of individual who provided the service/activity 8. Copy of activity log given to Case Manager within 3 working days after the end of each month. 9. Must be provided in a licensed Day Treatment Program 10. Staff ratio of no more than 8 clients ages 13 to 18 and no more than 5 clients for clients up through age 12. TOTAL POSSIBLE POINTS PER FILE: 14		

OTHER CONTRACT REQUIREMENTS

Part I: General Provisions 1.** Copy of PSA in file and services billed accordingly TOTAL POSSIBLE POINTS PER FILE: 1		**Currently not a contract requirement
<u>Incident Reports</u>: 1. Documentation of Incident as required by DCFS Incident Report reference guide: 2. Reported and sent to DCFS official (CM or CM Sup.) within 24 hours. TOTAL POSSIBLE POINTS PER INCIDENT: 2		

<u>Service Termination Summary</u> 1. Date of discharge 2. Progress on Goals 3. Recommendations for future treatment needs 4. Report sent to case manager within 15 days of discharge 5. Copy of report in client file **TOTAL POSSIBLE POINTS PER FILE: 5**		
<u>Onsite reconciliation of billings with client records</u> The Contractor shall submit monthly billings to the DHS/DCFS contractor monitor using the billing form specified by DHS/DCFS. Statements containing the following information for each client served shall be attached to monthly billing: (1) Client's name; (2) Service dates; (3) Start and end times of service; (4) Type of service provided; and (5) Number of billed units per client for each date. **TOTAL POSSIBLE POINT PER BILLING: 5**	`	

Service Codes: *Psychological Testing* NXH $132.44 ($120.95) Psychological Testing NXN $132.44 ($120.95) Neuropsychological Testing Battery NXD $132.44 ($120.95) Developmental Testing NXB $132.44 ($120.95) Neurobehavioral Status Exam *Mental Health Assessment/PDE* NCA $33.16/15 min. ($30.29) PDE, Mental Health Therapist NPE $33.16/15 min. ($33.16) PDE, MD/APRN NCN $33.16/15 min. ($12.29) Psychosocial Portion by Non-Mental Therapist *Psychotherapy* NFC $30.20/15 min. ($27.19) Individual Therapy NFT $27.19/15 min. ($27.19) Family Therapy w/Client NFW $27.19/15 min. ($27.19) Family Therapy w/o Client NGT $6.33/15 min. ($6.33) Group, Multi-Family NGT $6.33/15 min. ($6.33) Group, Non-Multi-Family *Pharmacologic Management* NMM $81.01 ($81.01) Pharmacologic Mgmt, Prescriber NMR $40.72 ($35.41) Parmacologic Mgmt, RN *Wrap Services* YIS $3.31/15 min. Intense Supervision Mentor/Tracker DGS 1.26/15 min. Day Group Support		

STAFF TRAINING REQUIREMENTS

The Contractor shall ensure that all staff and volunteers are trained and receive at a minimum **two hours** of training on the following topics **within the first week of employment and prior to working with Clients, and annually thereafter:** (a) Orientation to all requirements of DHS/DCFS contracts including, but not limited to, the review of "Use of Client Identifying Information and Electronic Media" indicated below. (b) Review of the DHS Provider Code of Conduct, which is then signed and placed in the individual's personnel file. (c) The Contractor's emergency management and business continuity plan, including emergency response and evacuation procedures. (d) The Contractor shall ensure that all workers assigned to provide services under this contract are trained in the DHS/DCFS Practice Model. Emergency/Crisis Intervention: The Contractor shall have a detailed written policy and procedure to address emergency/crisis situations. The policy shall address the Contractor's intervention procedures for handling emergency or crisis situations involving Clients and documenting the incident. The Contractor shall ensure all staff are trained annually on this policy and the training documented in staff files.		
Documentation for all training shall include: (a) Title and brief description of course content, (b) Date training completed. (c) Duration of training course. (d) Instructor name and qualifications that relate to the subject matter. (e) Employee signature, which shall include either a handwritten signature by the employee or an electronic signature, if training is completed electronically.		
BACKGROUND SCREENING		